Must be received by the Benefits Department within 31 days of the qualifying event.

Press Tab to begin filling out the form.

SF 4400-ADV (8-97)

☐ **Initial Enrollment** ☐ **Reinstatement from LOA** ☐ **Additional/Changes**

APPLICATION FOR SANDIA NATIONAL LABORATORIES' DENTAL & VISION CARE PLAN

Name (Last, First, Middle Initial)			Social Security Number	Job Type: (i.e. OAA, Clerk, MLS, MTS, STA, TA)
☐ Male ☐ Female	Date of Birth	Sandia Hire Date	Business Phone Number	Home Phone Number

Type of Coverage: (Employee Coverage)

☐ **DENTAL**	☐ **VISION**
☐ **Single**	☐ **Single**
☐ **Family***	☐ **Family***
☐ **Spouse of a Sandian****	☐ **Spouse of a Sandian****
☐ **Decline**	☐ **Decline**

*If you checked Family, list dependents below.
**If you and your spouse are employed by Sandia,
list your spouse's full name and social security number _____

Dependents to be Insured

Eligible Dependents are defined in the applicable "Summary Plan Descriptions."

						FOR BENEFITS USE ONLY	
Spouse's Name		Sex M/F	Birth Date	Social Security Number		Effective Date	Cancel Date
Dependent(s) Name(s)	Relationship to Employee***	Sex M/F	Birth Date	Social Security Number		Effective Date	Cancel Date

Note: If enrolling a handicapped dependent, call the Benefits Department (844-0358) for assistance.
***If a dependent is your stepchild, does this child reside in your home?

SNL Database Updated _____
Metlife-Dental Notified _____
MoO-Vision Notified _____

_____ _____
Employee Signature Date

Sandia National Laboratories
ATTN: BENEFITS ELIGIBILITY DESK
PO Box 5800 MS 1022
Albuquerque, NM 87185